State of Nevada Department of Human Resources
Division of Health Care Financing & Policy
Medical Care Advisory Committee (MCAC)
Minutes of Public Meeting on September 26, 2003

Agenda I The meeting was called to order by the Chairman Trudy Larson at 9:10am originating from Carson City with video conference to Las Vegas.

Agenda II Committee members constituting the necessary quorum were present as follows: Trudy Larson MD, Keith McDonald Pharm D, Jessie Harris, and Linda Sheldon by telephone, Patty Craddock DDS, Brad Lee MD, and Paul Boyar. Others present in each location are listed on the attached sign in sheets.

Dr. Larson welcomed and introduced Brad Lee MD, the State Health Officer for Nevada, and a new Committee member.

Agenda III Election of Committee Chairperson
Keith McDonald nominated Trudy Larson as committee chairman, and Linda Sheldon seconded the nomination. The vote was unanimous to elect Dr. Larson as Chairman of the Medical Care Advisory Committee for Nevada Medicaid for the year.

Agenda IV A motion by Keith McDonald to accept the minutes of the June 27, 2003 meeting was seconded by Paul Boyar, and adopted.

Agenda V Status of the recommendations to previous MCAC reviews of Medicaid Service Manual (MSM) chapters 900 and 3200.
The review of Chapter 900 will be delayed until the next MCAC meeting.
Julie Linnell, RN of DHCFP Hospice Services addressed the committee on Chapter 3200. She indicated the recommended items 1, 2, and 3 for Chapter 3200 have been accepted, the public hearings held, and the changes put into the newest version of the MSM which is now on the website and official policy.

Agenda VI The MSM chapter review process began on Chapter 500 Nursing Facility Services.
The chairman noted the addition of the cover page showing items which changed and the superceded item is very helpful to the members in the review process. Each section of the chapter was reviewed with committee members asking for explanations, definitions, and clarification on points in question. Responding to questions were Kay Panelli, RN of DHCFP in charge of Nursing Facility Services, and John Liveratti, Chief of the Compliance Unit. The following are items to be considered for change or inclusion in the chapter:

1. When a phrase or name will be used as an acronym, spell out at first use in chapter and follow with the acronym that will be used subsequently
2. In section 502.1, spell out MDS as this is first appearance in the chapter
3. Spell out QIO

Mr. McDonald asked for an explanation of a QIO-like vendor.

Dr. Larson asked for clarification on Section 503.6B, in the first paragraph, why a nursing facility would notify the Welfare Division about changes in assets of a patient.

Ms. Panelli explained in some cases the nursing facilities may handle patient funds. If a patient should receive a dividend check or any income which would raise the patient's funds over the maximum allowable asset level, Welfare is supposed to be notified. One option is that funds can be applied to a patient's expenses in the nursing facility, so that the maximum asset levels remain more stable.

Mr. Liveratti explained further that a nursing facility may not have the knowledge of an increase in assets in a timely manner. When the information is received, and reported, the welfare system will reduce benefits to the patient, the patient is required to pay more to the nursing facility thereby lowering assets, going back into full eligibility with the Welfare system. The cycle goes up and down in this fashion constantly and is a source of concern to all the entities involved as well as the patient and the patient's family.

Mr. Boyar indicated there should be a method to deplete assets which would not be punitive. The current allowable limit for a NF patient or his family to put into the patient's fund for personal items per month is $35, which is to cover hair cuts, grooming needs, toiletries, snacks, and even underwear. Should this amount be insufficient to cover those costs, and a family member comes in and wants to add $50 month to relative's spending money; it increases the asset and may become an issue which will be reported by the nursing facility to the welfare system. The cycle starts again with state benefit reduction, additional patient cost resulting in more expense and less income from the State.

Ms. Panelli stated the division proposed an increase to the personal needs funds in the 2003 Legislative session. A proposed $70 per month allowance did not make it to the Legislature.

Mr. Liveratti pointed out that while this would have helped, it is a reduction in the State General fund amount and would have to be considered in the 50/50 match funds. Even if it went to a Legislative BDR, it would not pass easily as it would require an increase in the Medicaid budget.

Dr. Larson replied the MCAC could recommend the change as a quality of life issue, or suggest a waiver to allow funds to be placed in a patient's account without being called assets.

Mr. Liveratti suggested the recommendation of the committee could be included in the DHCFP budget recommendations for the next session of legislature.

Dr. Larson reiterated it needs to be noted as a recommendation by the Committee in Chapter 500.

Mr. Liveratti said it would require notation as a waiver issue.

Mr. Boyar asked about the specific Federal regulations on patient funds and asset limits, and whether it is a state interpretation, or if it truly exists in Federal regulations. He stated it most definitely is a quality of life issue.

Mr. McDonald asked that both these topics be considered by the Board in discussion at a future meeting.

Ms. Sheldon agreed with Mr. McDonald, and asked that Medicaid staff research to determine what the cost would be to the State for a waiver, including the Federal match and consequences of the change.

Dr. Larson stated the consensus of the Committee was to proceed towards resolution of the issues of NF patient funds and the quality of life.

Chapter 500 review continued with a question on Personal Fund Audits, and how often they must be conducted.

Ms. Panelli responded they are done biennially.

Dr. Larson continued with a question about transportation and this section.

Ms. Panelli indicated there has been a transportation policy change. There is now a transportation broker who will deal with transportation providers and issues throughout the state. Nursing facilities will be able to access the transportation broker for services. The section/chapter on transportation was added to the Medicaid Services Manual.

Dr. Larson asked for a copy of the section, which was not available to distribute, however Ms. Panelli read the information for the Board. The text appears in Chapter 900, Section 903.A and B. The Board will receive the information with Chapter 900 for review at the next MCAC meeting.

Dr. Larson resumed the review of Chapter 500 at section 503.10.

At section 503.13A.7, Mr. Boyar asked about a plan for Medicaid to conduct level of care changes.

Ms. Panelli said yes, we are planning an annual review process that will include the review of each Medicaid recipient's level of care to determine if the recipient continues to meet the nursing facility level of care or if the recipient may be relocated to a community based setting. The waiver services are being expanded and will help with placing recipients in the community. The review process is currently being developed and the planned implementation date is January 2004.

Continuing the review, Mr. McDonald referred to page 28 and asked if, in the Federal regulations, there are guidelines as to how nursing facilities must operate.

Ms. Panelli indicated the nursing facility is required to be Medicare and Medicaid certified. The Bureau of Licensure and Certification through the Health Division surveys at least once a year, more often if there are complaints. The regulations are on the CMS website.

Dr. Larson asked if there might be more frequent reviews if a facility falls below the 40% standard.

Ms. Panelli replied that the nursing facility review process began about 2 years ago. About 1/3 of the existing facilities did not meet the 40% this year, but Medicaid staff is working with the facilities, and are also working with the Bureau to develop new training procedures to bring the ratings up.

Continuing, Dr. Larson asked if there are many routine out-of-state providers.

Ms. Panelli reported that there are about 70 patients out-of-state at any given time in 12 to 15 facilities used routinely.

The review completed, Mr. Boyar moved MCAC approval of the Nursing Facilities chapter as amended. The second was by Mr. McDonald and the motion adopted.

Dr. Larson began the review of Chapter 600 Physicians Services by asking that the word 'provider' be changed to 'physician' in all applicable instances in the chapter. Also the word 'out-recipient' should be changed to 'outpatient'.

Marti Cotè, RN of DHCFP Program Services indicated both of those changes had been made in the final draft of the chapter.

On Section 603, page 1, Dr. Larson asked that terminology 'ordered or performed by……..with parental supervision of physician' be changed to omit the word 'parental', and later in the section 'prognosis' be changed to 'profession.'

Mr. McDonald said he was still confused by the cross-references and use of the terms provider and physician and the differentiation between the two terms.

Ms. Cotè pointed out the disclaimer at the front of the chapter which explains the terms and their usage.

Dr. Larson continued the review, until Dr. Lee asked for clarification on page 8 of 603.1a, 1 in the last sentence. Explain what 'ante partum for non-legal non-resident' would be.

Ms. Cotè replied that would be emergency care only.

Mr. Liveratti said that when a non-legal woman delivers a child, then they can apply for Medicaid eligibility. When eligibility and service is approved, the hospital can apply for reimbursement retroactively.

Ms. Sheldon also stated that there is a waiver in some states for prenatal care for non-legal persons.

Mr. Liveratti replied that to incorporate that service, a budget concept presentation would be required and legislative action at a future time.

Ms. Sheldon indicated the costs of emergency services versus non-emergency delivery would make the concept feasible from a budgetary standpoint.

Dr. Larson continued the chapter review.

Mr. McDonald said he could find nothing in the chapter, which would prohibit a recurrence of the famous Nevada case in which a physician submitted for reimbursement when the baby had been delivered at home, and then brought to the emergency room as a stillborn. The mother and baby were cleaned up, and the physician billed for a full delivery.

Ms. Cotè stated she would check on that scenario.

Dr. Larson continued the review and at page 21 asked Ms. Cotè about when surgical procedures move from the experimental list to the approved list.

Ms. Cotè stated when the procedures are approved, Medicaid has a physician on staff who researches to see if it will be covered, depending on whether it falls into a mandatory or optional category.

Mr. Liveratti said the state is required by the State Plan to list what is covered. Children's services are covered under EPSDT, but for others this is the process.

Dr. Larson continued the review up to page 29.

Mr. McDonald asked the purpose of differentiating between recertification and Prior Authorization.

Ms. Cotè replied she would research to find the reason.

Dr. Larson continued through the chapter review.

Mr. Boyar why the limit was set at 24 visits per year for wound care.

Ms. Cotè responded additional visits would be based on medical necessity and requires prior authorization.

Dr. Larson led the committee through the review of the remainder of the chapter and invited public comments on the chapter.

There were no comments.

Ms. Sheldon moved acceptance of the chapter with the corrections and amendments noted. Jessie Harris seconded and the motion was adopted.

Dr. Larson thanked the Medicaid staff for the excellent work on the preparation of the chapter, and the committee members for their diligence in reviewing the chapters.

Mr. Liveratti requested the committee consider a special called meeting before the next quarterly meeting which is scheduled for December 12, 2003.

Robin Landry, Managed Care Unit of DHCFP, addressed the committee to ask they meet by mid-November to review and approve the new materials for HPN. The HPN materials must go to print in December so that they can meet the publishing and distribution date of January 1, 2004.

Dr. Larson asked the members if they would be agreeable to meet in mid-November instead of the scheduled December meeting. The HPN materials could be reviewed as well as the next chapters at that time.

Mr. McDonald also stated that his preference would be to review additional chapters at the upcoming meetings. When a meeting is scheduled and the members set aside a full morning for the MCAC, they should have sufficient materials to review to fill the allotted 3 hour time.

Mr. Liveratti indicated the budget concept format will also be sent to the committee, so that the members can begin to draft their ideas on the issues they want to address in the next biennium.

The committee members will be notified of the November meeting date as soon arranged.

The agenda items completed, Ms. Sheldon moved adjournment at 10:45am.

For additional details, there is an electronic recording available of this meeting.